



PA06 - GROWTH HORMONES
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
DXC Technology ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

CLIENT NAME: _____ DOB: ____/____/____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER () _____ FAX NUMBER () _____

DRUG REQUESTED: _____ QTY / FILL _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD10 CODE.

___ DOES THE PATIENT HAVE A DIAGNOSIS OF GH DEFICIENCY? ICD10 CODE _____

DUE TO: _____

OR

___ DOES THE PATIENT HAVE A DIAGNOIS OF CHILDHOOD ONSET? ICD10 CODE _____
GH DEFICIENT DURING CHILDHOOD AND CONFIRMED GH DEFICIENT AS AN ADULT PRIOR TO REPLACEMENT THERAPY.

ONE OF THE ABOVE AND THE FOLLOWING MUST BE DOCUMENTED FOR APPROVAL.

___ DOES THE PATIENT HAVE A BIOCHEMICAL DIAGNOSIS OF GH DEFICIENCY BY MEANS OF NEGATIVE RESPONSE TO GH STIMULATION TEST? (E.G. ARGINNE STIMULATION TEST) [Y/N]

COMMENTS: _____

PRESCRIBER SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT DXC TECHNOLOGY CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: ____ YES ____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____